Central Wyoming Skin Clinic

Patient Registration

Please complete in its entirety for clinic visit. If left incomplete, patient/guardian is refusing to be seen at the clinic and appointment will be canceled until further notice.

Full Legal Name: _____, _____ _____ **Social Security Number:** _____-_____-_____
Last First MI

Marital Status: Married / Single / Divorced / Widowed **Date of Birth:** _____/____/_____ **Birth Sex:** M / F
Month Day Year

Preferred Contact Method: Phone / Email / Letter **Can we leave a detailed message?** Y/N

Patient Ph: _____ - _____ - _____ **Can we send text reminders to this number?** Y / N

Email: _____ **Would you like to receive email notifications?** Y / N

Emergency Contact Full Name: _____ **Phone:** _____-_____-_____

Patient Billing Address: _____
Address Line 1

_____
Address Line 2

_____, _____ _____
City ST Zip

Is this a seasonal address? Y / N

If YES:

Start Date: _____ / _____
Day Month

End Date: _____ / _____
Day Month

Secondary Address: _____
Address Line 1

_____
Address Line 2

_____, _____ _____
City ST Zip

Is this a seasonal address? Y / N

If YES:

Start Date: _____ / _____
Day Month

End Date: _____ / _____
Day Month

Guarantor/Responsible Party: _____, _____ _____ **Date of Birth**: _____/_____/_____
Last Name First MI Month Day Year

Social Security Number: _____ - _____ - _____ **Is the address the same as the patient?** Y/ N

If NO: _____ **Phone Number:** _____ - _____ - _____
Address Line 1

_____ **Phone Number Type:** cell / home / work (circle one)
Address Line 2

_____, _____ _____ **Email:** _____
City ST Zip

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****ATTENTION** If Insurance card is not present at the time of the visit; the current visit will be deemed SELF PAY! ****

Payment Method: Insurance / Self Pay / V.A. **SELF PAY does not require completion of this section.**

Primary Insurance: _____ **Plan Name:** _____

Policy Number: _____ **Group Number:** _____

Policy Type: _____ **Name on Insurance Card**: _____, _____ **Is this the patient?** Y / N
Last Name First Name

Relationship to patient? Self / Spouse / Child / Other **Policy Holder Date of Birth:** _____ /_____ / _____ **Sex:** M /F

Is the address the same as the patient? Y / N If No: _____
Address Line 1

Policy Holder's Phone Number: _____- _____ - _____

_____
Address Line 2

_____, _____ _____
City ST Zip

Secondary Insurance: _____ **Plan Name:** _____

Policy Number: _____ **Group Number:** _____

Policy Type: _____ **Name on Insurance Card**: _____, _____ **Is this the patient?** Y / N
Last Name First Name

Relationship to patient? Self / Spouse / Child / Other **Policy Holder Date of Birth:** _____ /_____ / _____ **Sex:** M /F

Is the address the same as the patient? Y / N If No: _____
Address Line 1

Policy Holder's Phone Number: _____- _____ - _____

_____
Address Line 2

_____, _____ _____
City ST Zip

Pharmacy: _____ **Location Zip Code:** _____

Primary Care Provider: _____ **Location Zip Code:** _____

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Please list any Past Medical Conditions you want your provider to know of: _____
_____
_____
_____
_____
_____

Please list any Past Surgeries you want your provider to know of: _____
_____
_____
_____
_____

Please list any Skin Conditions you want your provider to know of: _____
_____
_____
_____
_____

Do you or any family member have a history of Melanoma? Y / N **If YES, Please list**: Self / Family: _____
_____
_____

CWSC can pull current prescription medications from your local pharmacy, do you authorize for us to do so? Y / N

Please list Medications you are currently taking: _____
_____
_____
_____
_____

Please list any Allergies: _____
_____
_____

Tobacco Usage: (circle one) **Please note the usage of a Vape still falls under "Smoking". **

Never / Heavy Current Smoker / Light Current Smoker / Current Smoker / Former Smoker / Cigar Smoker / Chewing Tobacco

Alcohol Usage: (circle one) None / Less than 1 drink a day / 1-2 drinks per day / 3 or more drinks per day

How many days in the past year have you had [females -4 drinks / males – 5 drinks] in one day? _____

Please list any Family Medical History you want your provider to know: _____
_____

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Patient Name: _____ **DOB:** _____

Medical Information Release

I authorize the release of medical information to my primary care or referring physician, to consultants (if needed and as necessary) to process insurance claims, insurance applications and prescriptions. I authorize the staff of Central Wyoming Skin Clinic to act as my representative for claims appeals when needed. I also authorize payment of medical benefits to my physician.

Full Name of Authorized person to access my medical records: _____

Patient or Legal Guardian Signature: _____ Date_____

Receipt of Notice of Privacy Practices/Written Acknowledgment

I have been notified and offered a copy of Central Wyoming Skin Clinic Notice of Privacy Practices.

Patient or Legal Guardian Signature: _____ Date _____

Financial Responsibility

I agree to pay for all services and products rendered to me immediately upon demand. I further agree that in the event of Non-Payments of any amounts due under this agreement, I will pay interest thereon at the rate of 1.75% per month and pay all reasonable attorney fees and court costs. I also agree that in the event this agreement is assigned to an agency for collection, I promise to pay an additional collection fee of 35% of the unpaid balance due.

Patient or Legal Guardian Signature: _____ Date_____

I understand that Central Wyoming Skin Clinic is a provider for the following insurance companies and that I am responsible for what my insurance does not pay.

The following are Insurance companies in network: Medicare, Railroad Medicare, Medicaid, Blue Cross Blue Shield, Cigna, Tricare, Department of Veterans Affairs/ Triwest.

I understand should my insurance be out of network Central Wyoming Skin Clinic will courtesy submit my claims to my insurance, and I will be responsible for any amount not covered.

Patient or Legal Guardian Signature: _____ Date _____